MEDICAL INFORMATION

REFERRED BY _____ EMAIL _____

NAME _____ MALE FEMALE

DATE OF BIRTH _____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____

_____

SOCIAL SECURITY NUMBER _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

SPOUSE _____ DATE OF BIRTH _____

SPOUSE PLACE OF EMPLOYMENT _____

METHOD OF PAYMENT CASH INSURANCE CARECREDIT

INSURANCE COMPANY _____ ID OR SS# _____

SUBSCRIBER NAME _____

PHYSICIAN NAME AND NUMBER _____

EMERGENCY CONTACT NAME _____

FOR THE FOLLOWING QUESTIONS CIRCLE YES OR NO

ARE YOU IN GOOD HEALTH YES NO

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR YES NO

ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO

IF YES, WHAT CONDITION ARE YOU BEING TREATED FOR? _____

HAVE YOU EVER HAD ANY SERIOUS ILLNESS, SURGERY OR HAVE BEEN HOSPITALIZED IN THE LAST 2 YEARS YES NO

IF YES, EXPLAIN _____

HAVE YOU EVER HAD HEART SURGERY, AN ARTIFICIAL HEART VALVE, OR BACTERIAL ENDO CARDITIS YES NO IF YES, EXPLAIN _____

_____

TURN OVER TO FINISH

CIRCLE ANY ILLNESSES THAT YOU HAVE OR HAVE HAD

HIGH BLOOD PRESSURE LOW BLOOD PRESSURE PACEMAKER

MEDICAL INFORMATION

HAYFEVER RESPIRATORY PROBLEMS

ASTHMA IF SO WHAT TRIGGERS ATTACKS _____

FAINTING SPELLS SIEZURES OR EPILEPSY, IF SO WHEN WAS LAST SIEZURE _____

DIABETES HEPATITIS AIDS OR HIV INFECTION THYROID PROBLEMS

TUBERCULOSIS CANCER CHEMO RADIATION

ARE YOU CURRENTLY RECEIVING CHEMO OR RADIATION

ABNORMAL BLEEDING BISPHOSPHONATES OR BONE BUILDING MEDICINE

ARTIFICIAL JOINTS, IF SO DATE OF SURGERY _____

PLEASE LIST ALL MEDICATIONS _____

_____

_____

ALLERGIES _____

HAVE YOU HAD TROUBLE WITH PREVIOUS DENTAL TREATMENT _____

DO YOU CURRENTLY USE TOBACCO YES NO IF SO WHAT KIND _____

ARE YOU PREGNANT YES NO

DO YOU STILL HAVE YOUR TONSILS AND ADENOIDS YES NO

DO YOU SNORE YES NO ARE YOU SLEEPY DURING THE DAY YES NO

HAVE YOU BEEN DIAGNOSED WITH SLEEP APNEA YES NO IF SO, DO YOU USE A CPAP YES NO

PATIENT SIGNATURE _____ DATE _____

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PATIENT SIGNATURE _____ DATE _____

PATIENT SIGNATURE _____ DATE _____

PATIENT SIGNATURE _____ DATE _____